



# APPLICATION CHECK LIST

## Copies:

- \_\_\_\_\_ Physical \*Date: \_\_\_\_\_ POINTS
- \_\_\_\_\_ Dental \*Date: \_\_\_\_\_
- \_\_\_\_\_ Birth Record
- \_\_\_\_\_ Shot Record
- \_\_\_\_\_ Insurance \_\_\_\_\_ IE
- \_\_\_\_\_ Income
- \_\_\_\_\_ Custody Papers
- \_\_\_\_\_ Care Plan/Allergy \_\_\_\_\_ OI
- \_\_\_\_\_ IEP/IFSP or Speech/Occupational/Physical Therapy

## Forms: (All need to be completed)

- \_\_\_\_\_ Release to form
- \_\_\_\_\_ 4 Page Health Form
- \_\_\_\_\_ Lead & Hemoglobin Permission Form
- \_\_\_\_\_ Lead Poisoning Assessment
- \_\_\_\_\_ Permission and Policy Form
- \_\_\_\_\_ CACFP Enrollment Form
- \_\_\_\_\_ Ethnic and Racial Data Form
- \_\_\_\_\_ Information Form
- \_\_\_\_\_ CSBG Form (include all family members and Social Security numbers)

CHILD'S NAME \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

AGE: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Sibling in Head Start? \_\_\_\_\_ EHS? \_\_\_\_\_

**RELEASE FORM FOR HCCAO HEAD START /EHS Infant and Toddler Classrooms**

Child's First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Parents' /Guardians' Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACTS:**

Please note that these contacts may be called and do have permission for your child to be released to, if you cannot be reached. (Contacts will be called in order that they are listed.)

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date name added: \_\_\_\_\_ Initials: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date name added: \_\_\_\_\_ Initials: \_\_\_\_\_

3. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date name added: \_\_\_\_\_ Initials: \_\_\_\_\_

4. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date name added: \_\_\_\_\_ Initials: \_\_\_\_\_

5. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date name added: \_\_\_\_\_ Initials: \_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

Ohio Department of Children and Youth  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth	First Day at Program/Home	
Home Address			City	
State	Zip Code	Home Telephone Number		
Parent/Guardian Name #1		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone (if applicable)		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Parent/Guardian Name #2		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name <u>of at least one person</u> who can be contacted in the event of an emergency or illness <b>if you cannot be reached</b> . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.				
Name		Name		
City	State	City	State	
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital				
Street Address				
City	State	Telephone Number		

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current health or medical condition** requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No  
 Yes - *check all that apply*     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No  
 Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No  
 Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No  
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No  
 Yes - a DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on file.  
 N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name

**Diapering Statement**

Is your child toilet trained?  Yes (If yes, skip to Emergency Transportation Authorization section)  
 No (If no, fill out the following:)

The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule  I do not agree, please check my child's diaper every \_\_\_\_\_ hours.

**Emergency Transportation Authorization**

<u>Give Permission to Transport</u>		<b>OR</b>  <b>Do not sign both</b>	<u>Do Not Give Permission to Transport</u>	
Program or Home Name <u>HCCAO HS/EHS</u>			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook.  Yes  No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

**Reset Form**



CHILD'S NAME: \_\_\_\_\_

1. Does your child live or regularly visit a house built before 1960?  Yes  No  Unsure
2. Was your child's daycare center or babysitter's home built before 1960?  Yes  No  Unsure
3. Does your home have peeling, chipping, dusting, or chalking paint?  Yes  No  Unsure
4. Have any of your children's playmates had lead poisoning?  Yes  No  Unsure
5. Does your child frequently come in contact with an adult who works with lead? (example: construction, pottery, welding, etc)  Yes  No  Unsure
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?  Yes  No  Unsure
7. Do you give your child any home or folk remedies which may contain lead?  Yes  No  Unsure
8. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?  Yes  No  Unsure
9. Does your child drink well water?  Yes  No  Unsure
10. Does your home have lead or copper pipes that are soldered with lead?  Yes  No  Unsure

**\*\*If you have answered "Yes" or "Unsure" to any of the above questions your child may be at risk for Lead Poisoning.**

**\*\*Lead Screenings on all children should occur at age 1 and 2 years old, or up to 6 years of age if no test has been administered.**

*There is no safe level of lead in the blood. Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead.*

**Parent/Guardian Signature that completed questionnaire:**

**Date:** \_\_\_\_\_



HCCAO HEAD START/EARLY HEAD START  
Lead & Hemoglobin Permission Form

Dear Parent/Guardian:

HCCAO Head Start/Early Head Start and WIC will be offering lead and hemoglobin screenings to children enrolled. The Health Services Manager for Head Start/Early Head Start and a nurse from the WIC office will perform these services.

In order for your child to participate, your signature and insurance information is required. Your signature will allow us to perform the test one time during the school year.

If your child has already received the lead and hemoglobin screenings, we will need a copy of these screenings from your doctor. If we do the screenings, a copy of the results will be sent to you.

Child's Information (Please Print)

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number # (Required) \_\_\_\_\_

Home Phone # \_\_\_\_\_

Please Check One (Please Print)

Name of Insurance \_\_\_\_\_ Medicaid \_\_\_\_ Private Insurance \_\_\_\_ No Insurance \_\_\_\_

- If you have private insurance, you will be notified of the date due to a \$15.00 fee for lead test

Parent/Guardian Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEAD START/ EARLY HEAD START

(Permission and Policy Form)

CHILD'S NAME: \_\_\_\_\_ CHILD'S BIRTHDATE: \_\_\_\_\_

1. I give Head Start and Early Head Start permission for my child to appear in photographs, films, local cable T.V. shows, newspapers, and videos. \_\_\_ yes \_\_\_ no
2. I give Head Start and Early Head Start my permission to release information from Help Me Grow and Job & Family Services for verification of cash assistance, food assistance and child support benefits. \_\_\_ yes \_\_\_ no
3. I give Head Start and Early Head Start my permission for my child to participate in all Head Start and Early Head Start screenings mandated by the Federal Performance Standards, during the school year in which my child is enrolled. (Height, weight, vision, hearing, speech, educational, and developmental.) \_\_\_ yes \_\_\_ no
4. I give my permission to Head Start and Early Head Start to have my child's health record and screening results sent to the appropriate public school or any other agency.  
(PLEASE LIST CHILD'S SCHOOL DISTRICT \_\_\_\_\_.) \_\_\_ yes \_\_\_ no
5. I give my permission for Head Start/Early Head Start to provide mental health consultation services. \_\_\_ yes \_\_\_ no
6. I give my permission for Head Start and Early Head Start to obtain medical and dental information from any physician or dentist office and any hospital or clinic my child has been a patient. \_\_\_ yes \_\_\_ no
7. I give Head Start and Early Head Start my permission to have my child's personally identifiable information (name, birthdate, phone number, address, etc.) sent to my child's school district or other agency if requested. \_\_\_ yes \_\_\_ no
8. I give Head Start and Early Head Start my permission to have my child's Creative Curriculum (DRDP)) information sent to my child's school district. \_\_\_ yes \_\_\_ no
9. During Head Start and Early Head Start program reviews, all regulatory authorities could have access to review your child's file. \_\_\_\_\_  
**Parent Initials**

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## GRIEVANCE PROCEDURES

**Grievance / complaint must be in writing and signed by the person who makes the complaint. Unsigned grievances or complaints will not be answered.**

1. Grievance / complaints are then submitted to the Family Engagement Manager who will in turn give it to the Director of Early Childhood Program. If preferred the grievance / complaint may be submitted to the Director of Early Childhood Program directly.
2. The Director shall have 10 days to resolve the grievance or will present it to the Policy Council for discussion.

I give my permission for the above items and have read and understand the grievance procedures.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# H.C.C.A.O. HEAD START / EARLY HEAD START INFORMATION SHEET

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Mother's Name \_\_\_\_\_ DOB \_\_\_\_\_ Mother in Home? \_\_\_\_\_

Father's Name \_\_\_\_\_ DOB \_\_\_\_\_ Father in Home? \_\_\_\_\_

Number in Family \_\_\_\_\_ Number in Household \_\_\_\_\_ Is the Child You are Enrolling a Foster Child? \_\_\_\_\_

Do You Have Custody Papers? \_\_\_\_\_ Shared Parenting? \_\_\_\_\_

Are You a Past Head Start/Early Head Start Parent? \_\_\_\_\_

Do You Live with Someone Else? \_\_\_\_\_ Who? \_\_\_\_\_ Are You Homeless? \_\_\_\_\_

Name the Other Family Members in the Home: (i.e.: siblings, grandparents, Aunts, Uncles, etc.....)

1. \_\_\_\_\_ Relationship to Child \_\_\_\_\_ DOB \_\_\_\_\_
2. \_\_\_\_\_ Relationship to Child \_\_\_\_\_ DOB \_\_\_\_\_
3. \_\_\_\_\_ Relationship to Child \_\_\_\_\_ DOB \_\_\_\_\_
4. \_\_\_\_\_ Relationship to Child \_\_\_\_\_ DOB \_\_\_\_\_

Mother's Educational Level \_\_\_\_\_ Graduated? \_\_\_\_\_ Father's Educational Level \_\_\_\_\_ Graduated? \_\_\_\_\_

Parents/Guardian in School or Training? \_\_\_\_\_ Where? \_\_\_\_\_ Grad. Date \_\_\_\_\_ Degree \_\_\_\_\_

Are You Employed? \_\_\_ Full Time \_\_\_ Part Time \_\_\_ Spouse Employed? \_\_\_ Full Time \_\_\_ Part Time \_\_\_

Are You Employed Less Than One Year? \_\_\_\_\_ Spouse Employed Less Than a Year? \_\_\_\_\_

Do You Use Childcare? \_\_\_\_\_ Who? \_\_\_\_\_ Do You Have Subsidized Childcare? \_\_\_\_\_

Was Your Child in Early Head Start? \_\_\_\_\_ Was Your Child in Help Me Grow? \_\_\_\_\_ Do You Receive WIC? \_\_\_\_\_

Do You or Anyone in Your Family Receive SSI? \_\_\_\_\_ Who? \_\_\_\_\_ Do You Receive TANF? \_\_\_\_\_

Do You Receive OWF? \_\_\_\_\_ Do You Receive a Food Card? \_\_\_\_\_ Do You Have Medical Insurance? \_\_\_\_\_

What Kind of Insurance? \_\_\_\_\_ Were You a Teen Parent? \_\_\_\_\_ Are You Pregnant? \_\_\_\_\_

Parent/ Guardian / Spouse Incarcerated? \_\_\_\_\_

Does Your Child Have a Disability? \_\_\_\_\_ IEP \_\_\_\_\_ Does Parent / Guardian Have a Disability \_\_\_\_\_

Were You Referred by a Child Welfare Agency? \_\_\_\_\_ Who? \_\_\_\_\_

Was Your Child on a Waiting List Last Year? \_\_\_\_\_

Is Anyone in Your Family Receiving Mental Health Counseling or Treatment? \_\_\_\_\_

Do You Have Any Concerns About Your Child's Behavior? \_\_\_\_\_ What? \_\_\_\_\_

How Did You Hear About the Head Start Program? \_\_\_\_\_

**\*I hereby certify that all information provided in the application is true and accurate**

PARENT/ GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# ETHNIC and RACIAL DATA FORM

Agency/Daycare Center HCCAO HS/EHS

Agency/Daycare Address \_\_\_\_\_

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

★ Child's name: \_\_\_\_\_

Ethnic Category: \_\_\_\_\_

★ <b>Hispanic or Latino:</b> A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
<b>Non-Hispanic or Latino:</b>	

★ Racial Categories: Check all that apply

<b>American Indian or Alaska Native:</b> A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
<b>Asian:</b> A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
<b>Black or African American:</b> A person having origins in any of the black racial groups of Africa.	
<b>Native Hawaiian or Other Pacific Islander:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
<b>White:</b> A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
<b>Other</b>	

★ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ ★

Ohio Department of Education and Workforce - Office of Nutrition  
**CHILD AND ADULT CARE FOOD PROGRAM**  
**ENROLLMENT FORM**

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

**Instructions to Complete**

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

**CENTER NAME**

HCCAO EHS/HS

**CHILD'S NAME**

(please print)

**AGE**

**BIRTHDATE**

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE  
 AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday	8:30			3:30	✓		✓	✓		
Tuesday	8:30			3:30	✓		✓	✓		
Wednesday	8:30			3:30	✓		✓	✓		
Thursday	8:30			3:30	✓		✓	✓		
Friday	8:30			3:30	✓		✓	✓		
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF  
 PARENT/GUARDIAN**

**DATE**

**DAY PHONE  
 NUMBER**

**MAILING ADDRESS  
 STREET /APT.**

**CITY**

**ZIP CODE**

**PARENT BIRTHDATE**

month / day / year

**PARENT EMAIL**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDAOASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form or letter must be submitted to USDA by:  
 (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (833) 256-1665 or (202)690-7448; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider

Revised 8/2024

# CHILD AND ADULT CARE FOOD PROGRAM INFANT MEALS – PARENT PREFERENCE LETTER

**TO:** Parents and Guardians of Infants under one year of age

**FROM:**

**NAME OF CENTER/PROVIDER**

HCCAO EAS

**TOPIC:** Who will provide food for your infant's meals?

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a U.S. Department of Agriculture (USDA) child nutrition program. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

**NAME OF FORMULA**



A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section. When a child is developmentally ready, parents can provide only one component (food or formula) as part of a reimbursable meal or snack.

**PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD**

**Formula or Breast Milk: (check one)**

- I want the center or FCC home provider to provide formula for my infant
- I will bring iron fortified infant formula for my infant
- I will bring expressed breast milk for my infant
- I will come to the center or FCC home to breast feed my infant

**Parent/Guardian: List Name of Formula You Will Provide**

**Solid Food: (check one)**

- I want the center or FCC home to provide all solid foods for my infant when he/she is developmentally ready
- I will bring one solid food item for my infant when he/she is developmentally ready for it and the center will provide all other required components including formula.

**\*Note: If your feeding preferences change, you will be asked to complete a new form.**

**INFANT NAME:**

**INFANT BIRTHDATE:**

**PARENT/GUARDIAN SIGNATURE:**

**DATE:**

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

<b>Client Number:</b>		<b>Agency:</b> Highland County Community Action Org. Inc.		<b>Application Date:</b>	
<b>Primary Applicant First Name</b>		<b>M.I.</b>		<b>Last Name</b>	
<b>Social Security Number</b> ____/____/____		<b>Date of Birth</b> ____/____/____		<b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Male	
<b>Household Information:</b>					
<b>Household Size:</b>		<b>Family Type</b>		<b>Building Type</b>	
<b>Housing Status</b>					
<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other		<input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Non-related Adults with children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other		<input type="checkbox"/> Mobile Home <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-family low rise (3 stories or less) <input type="checkbox"/> Multi-family high rise (3 stories or more)	
<b>Customer Address:</b>					
<b>Current Service Address:</b>			<b>Apartment/Lot/Unit Floor:</b>		
<b>Current Mailing Address (if different from above):</b>			<b>Apartment/Lot/Unit Floor:</b>		
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	
				<b>County:</b>	
<b>Phone Number:</b>			<b>Email Address:</b>		
<b>Preferred method of contact?</b>					
<b>Primary Applicant Demographic Information:</b>					
<b>Ethnicity</b>		<b>Race</b>		<b>Education</b>	
<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White		<input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school	
<b>Client Disabled?</b>		<b>Military Status</b>		<b>Is Client a US Citizen?</b>	
<input type="checkbox"/> Yes		<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military		<input type="checkbox"/> Yes	
<b>Work Status</b>		<b>Health Insurance Type</b>		<b>Non-Cash Benefits</b>	
<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults		<input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC	

Adult info this page

<b>First Name</b>	<b>M.I.</b>	<b>Last Name</b>
<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Gender</b>
___/___/___	___/___/___	<input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Male
<b>Ethnicity</b>	<b>Race</b>	<b>Education</b>
<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White	<input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school
<b>Client Disabled?</b>	<b>Military Status</b>	<b>Is Client a US Citizen?</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military	<input type="checkbox"/> Yes
<b>Work Status</b>	<b>Health Insurance Type</b>	<b>Non-Cash Benefits</b>
<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC
<b>First Name</b>	<b>M.I.</b>	<b>Last Name</b>
<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Gender</b>
___/___/___	___/___/___	<input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Male
<b>Ethnicity</b>	<b>Race</b>	<b>Education</b>
<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White	<input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school
<b>Client Disabled?</b>	<b>Military Status</b>	<b>Is Client a US Citizen?</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran <input type="checkbox"/> Active Military	<input type="checkbox"/> Yes
<b>Work Status</b>	<b>Health Insurance Type</b>	<b>Non-Cash Benefits</b>
<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC

*other family members here*

**ADDITIONAL HOUSEHOLD MEMBERS**

<b>First Name</b>	<b>M.I.</b>	<b>Last Name</b>
<b>Social Security Number</b> ____/____/____	<b>Date of Birth</b> __/__/____	<b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Male
<b>Ethnicity</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins	<b>Race</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White	<b>Education</b> <input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school
<b>Client Disabled?</b> <input type="checkbox"/> Yes	<b>Military Status</b> <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military	<b>Is Client a US Citizen?</b> <input type="checkbox"/> Yes
<b>Work Status</b> <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school	<b>Health Insurance Type</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults	<b>Non-Cash Benefits</b> <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC
<b>First Name</b>	<b>M.I.</b>	<b>Last Name</b>
<b>Social Security Number</b> ____/____/____	<b>Date of Birth</b> __/__/____	<b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Male
<b>Ethnicity</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins	<b>Race</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White	<b>Education</b> <input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school
<b>Client Disabled?</b> <input type="checkbox"/> Yes	<b>Military Status</b> <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military	<b>Is Client a US Citizen?</b> <input type="checkbox"/> Yes
<b>Work Status</b> <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school	<b>Health Insurance Type</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults	<b>Non-Cash Benefits</b> <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC

*Other family members here*

Customer Name:	Total Amount Received	Period Received (30, 90 or 365 days)
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	

Income Category:		Frequency:	Total Amount:
<input type="checkbox"/> Fixed	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> SSA <input type="checkbox"/> Pension <input type="checkbox"/> Window/Widower's benefit <input type="checkbox"/> Adoption Assistance <input type="checkbox"/> Alimony <input type="checkbox"/> Black Lung pension	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Earned	<input type="checkbox"/> Wages <input type="checkbox"/> Self-employment <input type="checkbox"/> Active Military Pay <input type="checkbox"/> Ohio Electronic Child care	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Supplemental	<input type="checkbox"/> Unemployment <input type="checkbox"/> Utility Assistance <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Ohio Works First (TANF, ADC)	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Other	<input type="checkbox"/> Cash withdraws from: IRA, Annuities, Other investments <input type="checkbox"/> Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings <input type="checkbox"/> Interest Income	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> None			\$ _____
<b>Total:</b>			\$ _____

<b>Deductions:</b>		
Deductible Income:	Frequency:	Total Amount:
<input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Health Care Spending Accounts <input type="checkbox"/> Medicaid Spend Down (deductibles) <input type="checkbox"/> Medicare Part D (RX premium) <input type="checkbox"/> Child Support paid-out <input type="checkbox"/> Attorney fees for estate or trust settlements	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<b>Total Household Income (Countable Income – Deductions)</b>		\$ _____
<b>Federal Poverty Level:</b>		_____ %

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

**Excluded Income**

Excluded Income:	Frequency:	Total Amount:
<input type="checkbox"/> Agency Orange Pension <input type="checkbox"/> Veterans affairs, service related disability <input type="checkbox"/> Handicapped income (i.e. work programs for the blind or disabled) <input type="checkbox"/> Title V wages (i.e. senior employment programs) <input type="checkbox"/> Volunteers in Service to America Stipend (VISTA) <input type="checkbox"/> Work allowances (work requirement to receive OWF assistance) <input type="checkbox"/> Income earned by dependent minors <input type="checkbox"/> Tax refunds/rebates <input type="checkbox"/> Education assistance (grants stipends for tuition/books) <input type="checkbox"/> Stipends for foster care <input type="checkbox"/> Military allowances for subsistence <input type="checkbox"/> Ohio waiver program (Medicaid benefit for caregiver) <input type="checkbox"/> Prevention retention and contingency (i.e. emergency services, rental asst.) <input type="checkbox"/> transportation allowances (WIOA) <input type="checkbox"/> Proceeds from reverse mortgage <input type="checkbox"/> FEMA, cash payments <input type="checkbox"/> Title III Disaster relief emergency assistance	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____

**Expenses:**

Expense Type:	Total Monthly Expense amount:
Food	\$ _____
Shelter	\$ _____
Child Care	\$ _____
Transportation	\$ _____
Utilities	\$ _____
<b>Total:</b>	\$ _____

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
---------------------------------------	---------------

**Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):**

**Section A- EXAMINATION**

- The above named child has been examined.
- The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).
- The above named child does not have allergies OR is allergic to the following (*please list in space below*):

*Check below, if applicable:*

- Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____	Vision _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.**

<p><b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b>  <b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b>            Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.</p>	
<p><b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b></p> <p><input type="checkbox"/> The above named child has been immunized against the diseases listed above.</p> <p><i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i></p>	<p>Initials of Examining Health Care Practitioner</p> <hr/> <p>Date</p>
<p><b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b></p> <p><input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):</p>	<p>Signature of Parent</p> <hr/> <p>Date</p>



Good nutrition today means a stronger tomorrow!

# Building for the Future

## with CACFP

This day care  
receives support  
from the Child and  
Adult Care Food  
Program to serve  
healthy meals to your children.



**Meals served here must meet USDA's  
nutrition standards.**

### **Questions? Concerns?**

*[HCCAO HS/EHS 1487 N. High St Suite 500 Hillsboro, Ohio 45133]*

Learn more about CACFP at USDA's website:

<https://www.fns.usda.gov/>

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture  
Food and Nutrition Service FNS-317  
November 2019

# Building For the Future

This childcare facility participates in the Child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

**Meals** CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five components)
Milk Fruit OR Vegetable Grains or Bread* *Meat/Meat Alternate may replace entire grain up to 3x/week	Milk Meat or meat alternate Grains or bread Vegetable AND Fruit or Second Vegetable (If serving two vegetables they must be different foods)	Milk Meat or meat alternate Grains or bread Fruit Vegetable

## Participating

**Facilities** Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit childcare centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

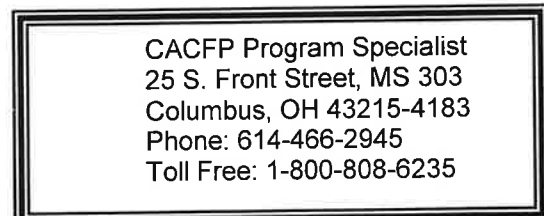
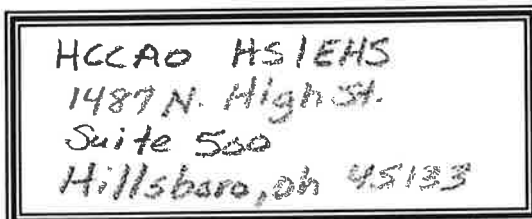
**Eligibility** State agencies reimburse facilities that offer non-residential day care to the following children:

- Children aged 12 and under,
- Migrant children aged 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

**Contact Information** If you have questions about CACFP, please contact one of the following:

**Sponsoring Organization/Center**

**Ohio Department of Education**



## Nondiscrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).